AGREEMENT REGARDING DIRECT FINANCIAL ASSISTANCE PAYMENTS

THIS AGREEMENT is entered into and between the Department of Human Services, Division of Services for People with Disabilities Administrative Office and Division's _____ Region, hereinafter referred to as STATE, and _____,

(Address)_____,
(Telephone) _____, (Social Security #) _____,
to provide services for (Persons I.D.#) _____. This Agreement shall be in effect on _____, 20____ and shall be terminated on _____, 20____.

Funds for Direct Financial Assistance funding Grant shall be used for the purpose of:
_____
_____
_____
_____
_____
_____.

It is my understanding that in receiving these funds that I will use the funds for the purposes stated above and will be responsible for keeping a log of the expenses incurred and make that log available to State and Regional representatives upon request. I also understand that I am responsible to establish, with the assistance of the Support Coordinator, my need for supports / services and comply with the objectives set forth in my Family Support Plan / Individual Plan. I understand that my receipt of these funds is contingent on availability of funds.

This Agreement may be terminated by any party with or without cause upon thirty (30) days written notice.

_____
Person

_____
Parent / Legal Representative

_____
Support Coordinator

Department of Human Services

_____ _____
Authorized Representative Date

Address

_____
Title